SECURITY BENEFIT℠
To and Through Retirement

Security Flex 125 Program®

Flexible Spending Account Manual

Table of Contents

Flexible Spending Accounts Guidelines

You can access your account information 24-hours a day through our website at **www.securityflex.com**

Your Account

Medical and Dependent Care Flexible Spending Accounts are designed to allow you to pay for eligible medical and dependent care expenses with tax-free dollars. This reduces your federal income tax and, in most cases, your social security taxes are also reduced.

During the annual enrollment period, you select the amount to be withheld from each paycheck by your employer. The funds are sent to Security Benefit and deposited into your Flexible Spending Account (FSA).

Contribution amounts are designated on an annual basis and cannot be altered unless you experience a change in family status. Please contact your employer regarding family status changes. **Election changes must be made within 30 days of the date of family status change.**

The explanation of benefits, which is sent upon the completion of each claim that is paid, provides you with information regarding your account balance, claims paid to date and claims pending.

In addition to the detailed explanation of benefits that you will receive with each paid claim, we send periodic statements. These statements reflect year-to-date transactions and should be reviewed carefully to determine remaining balances and pending claims.

Claims

You may send in claims throughout the year. Only claims for services incurred during the plan year are eligible for reimbursement. In accordance with Internal Revenue Service guidelines, money remaining in the plan at the end of the plan year will be forfeited if a claim for reimbursement is not submitted within 90 days following the close of the plan year for claims that were incurred during the year. **It is important that you plan your deposits carefully. Please remember that unused amounts may not be carried forward into the next plan year.**

A claim form is attached to use when submitting a flexible spending claim. You must attach photocopies of all receipts to the claim form for processing. **Please remember to sign the claim form. Claim forms received without a signature will be returned to you.**

On the back of the claim form is space for you to itemize your claims. This is useful when you have multiple reimbursable claims with varying amounts. This worksheet allows you to review your claims and ensure that they contain all required information.

Please note: All claims received will be retained at Security Benefit and will not be returned once received.

Example

John River pays his day care provider on March 1 for March day care. He immediately sends in his claim for reimbursement. **Why doesn't he receive his reimbursement until the end of the month?**

Answer

The IRS has indicated that expenses are not reimbursable until the expense has been incurred. Day care expenses claimed are for the time you and your spouse go to work. Therefore, expenses will not be incurred until the end of March. Your claim will be held until the end of the month before being processed.

You should check with your employer to determine when the dependent care deposits will be sent to Security Benefit. According to IRS regulations, dependent care reimbursements cannot be made until Security Benefit has received the employer's deposit. Therefore, your claim could be received, processed and pended until the employer's deposit is received. Once that deposit and your claim have been received, a payment will be mailed to you or an automatic deposit will be directed to your bank.

Medical Claims

Many forms of documentation are acceptable for medical claims. The most frequently received types of claims are statements and billings of accounts. We are not able to accept statements showing "received on account" or "balance due" or a cancelled check. Eligible statements must include:

- the provider's name and address
- date of service
- for whom the service was provided
- charges for the date of service
- service(s) provided

Please be certain copies of receipts are legible. A list of allowed expenses is provided on page 3.

Reimbursement claims received by mail are processed within one to three business days after they are received in our office. You should receive reimbursement of your claims within seven to 10 business days. See below regarding reimbursement of dependent care claims.

Dependent Care Claims

If you are claiming dependent care expenses, you will need to obtain a receipt from your child-care provider, with the provider's signature, that states the dates for which you are paying. Only charges for preschool and day care are eligible for reimbursement. You will need the provider's name, address and social security number or tax identification number for your records.

Dependent care expenses must be incurred before reimbursement can be made. For example, if you prepay your day care provider at the first of the month, you cannot submit a claim for those expenses until the services have been incurred. IRS regulations specifically mandate, "A Flexible Spending Account cannot make advance reimbursement of future or projected expenses."

Flexible Spending Accounts Summary

Medical Expenses*

The following is a partial listing of medical expenses which are allowed and disallowed through your FSA. Please refer to IRC Section 213(d) for a complete listing of allowed expenses.

ALLOWED MEDICAL EXPENSES

- Acupuncture
- Ambulance
- Chiropractor fees
- Coinsurance (co-pays and deductibles for health, dental and vision)
- Corrective eye surgery
- Crutches (purchase or rental)
- Hearing aids and hearing aid batteries
- Hospital services
- Immunizations
- Insulin and equipment needed to inject the insulin
- Laboratory fees
- Massage therapy with letter stating medical necessity
- Medicines (prescriptions)
- Nursing services-connected with caring for the patient
- Organ donation/transplantation
- Orthodontic fees
- Over the counter medicines (with prescription)
- Prescription eyeglasses, sunglasses, Contact Lenses and solutions associated with their care
- Physical, Dental and Eye exams
- Prosthesis
- Psychoanalysis, Psychiatric & Psychological treatment/fees
- Reading glasses
- Surgery/operations
- Transportation-amounts primarily for and essential to medical care
- Weight-loss program and/or drugs to induce weight loss when prescribed for a specific diagnosis
- Well-child care
- Wheelchair
- X-ray fees

DISALLOWED MEDICAL EXPENSES

- Chapped lip treatments
- Cosmetic surgery (expenses exceptions if medically necessary)
- Dancing lessons, swimming lessons, etc., even if recommended for the general improvement of your health
- Diaper service
- Electrolysis or hair removal
- Face creams, moisturizers, suntan lotions
- Funeral Expenses
- Hair transplant (i.e. Rogaine, Propecia)
- Health Club dues
- Household help
- Insurance premiums – for individual and/or spouses health, dental, and/or policies covering loss of earnings, loss of a limb or eyesight
- Maternity clothes
- Medicated shampoos and soaps (unless prescribed by a doctor)
- Psychoanalysis received as part of training to be a psychoanalyst
- Sunscreen
- Teeth Bleaching
- Toiletries
- Toothbrushes, toothpaste
- Vitamins and supplements for maintaining general good health

ALLOWED OVER-THE-COUNTER MEDICATIONS

Reimbursable:

- Bandaids, bandages, gauze pads, first aid kits
- Cold/hot packs for injuries, crutches
- Contact lens solution, cleaners
- Carpal tunnel wrist supports
- Condoms, spermicidal foam
- Insulin
- Nasal strips for snoring
- Orthopedic shoe inserts
- Pregnancy test kits
- Reading glasses
- Thermometers (ear or mouth)

Reimburseable with a doctor's prescription:

- Antacids
- Allergy medication
- Anti-diarrheal medication, laxatives
- Bug bite medication
- Calamine lotion
- Cough drops, throat lozenges, sinus medication, nasal sinus spray
- Cold medication, pain reliever
- Diaper rash ointment
- First aid creams and ointments, liquid adhesives, topical ointments
- Glucosamine/chondroitin for arthritis or other medical condition
- Health Club dues (requires a doctor's statement and must be to treat a disease, if the participant belonged to the health club before being diagnosed, then the dues would not be reimbursable)
- Hemorrhoid creams
- Incontinence supplies
- Joint/muscle pain medication
- Lactose intolerance pills
- Medicated shampoos and soaps
- Menstrual cycle products for pain and cramp relief
- Motion sickness pills
- Nicotine gum or patches for stop-smoking purposes
- Over the counter hormone therapy and treatment for menopausal symptoms (hotflashes, night sweats, etc.)
- Prenatal vitamins during pregnancy
- Rubbing alcohol
- Sleeping aids
- St John's Wort for depression
- Suppositories
- Sunburn cream or ointment
- Supplements, vitamins or herbal treatments to treat medical condition
- Wart remover treatments
- Weight loss drugs to treat medical condition or obesity

**It is possible that changes in the IRS rules can affect the Allowed and/or Disallowed Expenses categories.*

Dependent/Day Care Expenses*

Dependent/day care expenses include payments you make for the care of a child under 13 and/or a dependent regardless of age who requires care due to an inability to care for him or herself, to enable you (and, if married, your spouse) to remain gainfully employed.

For dependents to be eligible, they must be unable to care for themselves and must spend at least eight hours a day in your home. You must declare them as dependents (or have the ability to declare them as dependents except for their level of gross income) on your Federal tax return. Reimbursement for amounts cannot be claimed if paid to your spouse, anyone you claim as a tax dependent, or your child under age 19. Any expenses reimbursed through your account cannot be claimed for income tax purposes.

Please remember day care expenses must be incurred to be eligible for reimbursement.

ALLOWED DEPENDENT/ DAY CARE EXPENSES	• Licensed day care facility • Preschool program • In-home child and dependent care services	• Day camp expenses • Elder care	• Any other qualified dependent care expenses as defined by the IRS
DISALLOWED DEPENDENT/ DAY CARE EXPENSES	• Overnight camp	• Services solely for the purpose of household cleaning	• Day care for children past their 13th birthday

**It is possible that changes in the IRS rules can affect the Allowed and/or Disallowed Expenses categories.*

Reasons Why Claims May Not Be Reimbursed

All claims received will be processed. However, only those claims that are eligible for reimbursement according to IRS regulations will be reimbursed. Claims received that are not eligible for reimbursement will be kept in your Security Benefit file. You will receive a letter indicating the reason that the claim is ineligible for payment. If you have some claims that are reimbursable and some that are not, you will receive an explanation of benefits. The explanation of benefits will list reasons why ineligible claims could not be paid.

Many scenarios exist that may prevent or delay processing of a claim. The most frequent reasons are listed below. **The boldfaced portion will appear on your explanation of benefits as listed below. Please refer to this list to troubleshoot your claim.**

Reasons

Covered by Insurance – A portion of your claim has been denied because the amount was covered by your insurance company and is not eligible for reimbursement under this FSA plan.

Max Contribution Paid Out – The full account value for the plan year has been reimbursed to you.

Calculated Incorrectly – Your claim has been posted to your account; however, one or more of your expenses were calculated incorrectly.

Unacceptable Rx Receipt – A portion of your claim has been denied because prescription drug expenses must include a pharmacy receipt or a copy of the insurance Explanation of Benefits (EOB). Cash register tape receipts are not acceptable.

Cosmetic Exp Ineligible – A portion of your claim has been denied because the expense appears to be cosmetic in nature. Cosmetic expenses are not eligible for reimbursement per IRS regulations.

Duplicate Expense – A portion of your claim has been denied because the expense has been previously submitted and posted to your FSA account.

Expense Not in Plan Year – A portion of your claim has been denied because the expense was not incurred within the current plan year. The incurred date is the date the service was rendered or the date the item was purchased.

Expense After Termination – A portion of your claim has been denied because expenses incurred after your termination date are not eligible for reimbursement. The incurred date is the date the service was rendered or the date the item was purchased.

Benefit Statement Unclear – A portion of your claim was denied because your Explanation of Benefits (EOB) indicated that the expense was denied or not eligible, but it does not indicate the type of service and/or why it was denied/ineligible. Please submit an itemized receipt containing all of the following: provider's name, date(s) of service, type of service, patient's name and the fee for each service.

Finance Charges Ineligible – A portion of your claim was denied because finance charges, late fees and interest charges are not eligible for reimbursement.

Reasons *(continued)*

Rec'd on Acct/Balance Due Ineligible – Statements showing "ROA," "Balance Forward" or other similar statements are not acceptable. Please provide an Explanation of Benefits (EOB) from your insurance company or an itemized statement detailing the non-reimbursable amount. The itemized statement should include all of the following: the provider's name, date(s) of service, type of service, patient's name and the non-reimbursable amount for each service.

Plan Year Deadline Expired – A portion of your claim was denied because the deadline for filing claims for the prior plan year has expired. The deadline is 90 days after the last date of the plan year.

Itemized Receipt Required – A portion of your claim was denied because we did not receive an itemized receipt. The itemized receipt or statement should include all of the following: the provider's name, date(s) of service, type of service, patient's name and the non-reimbursable amount for each service.

Fax'd Receipt Not Readable – A portion of your claim was denied because the faxed receipt received was not readable.

Receipt Unacceptable – A portion of your claim was denied because the receipt was unacceptable. The itemized receipt or statement should include all of the following: the provider's name, date(s) of service, type of service, patient's name and the non-reimbursable amount for each service.

Date of Service in the Future – A portion of your claim was denied because the actual date of the service is in the future. We can only reimburse expenses that are actually incurred during the plan year. We cannot reimburse for services not yet provided or for Overpayment Reduction (a portion of your claim was applied toward an overpayment balance).

You will have 180 days following receipt of this notification in which to appeal the decision.

Appeals should be directed to:
Benefit Claims Administration
ERISA Appeals Administrator
PO Box 750600
Topeka KS 66675-0600

You may submit written comments, documents, records and other information relating to the claim. If you request, you will be provided reasonable access to and copies of all documents, records and other information relevant to the claim free of charge.

Upon receipt of additional information related to the claim, we will review the claim and provide a written response to the appeal within 60 days. (This period may be extended an additional 60 days under certain circumstances.)

You also have the right to bring a civil action under section 502 of ERISA following denial of a claim.

SECURITY BENEFIT®

Security Flex 125 Program®

Letter of Medical Necessity

Patient Name: _____

Participant Name: _____

Participant's Employer: _____

Participant SSN: _____

This form should be completed by the attending physician to confirm treatment is necessary for a specific medical condition. Complete the following:

1. Describe the diagnosed medical condition being treated. (Include diagnosis code):

_____

_____

_____

2. Describe the recommended treatment:

_____

_____

_____

3. Indicate the duration of treatment:

_____

_____

_____

This treatment is medically necessary to treat the specific medical condition described above. This treatment is not in any way for general health; and is not for cosmetic purposes to improve appearance.

_____ _____
Signature of Attending Physician Date

_____ _____
Physician's Name Printed Phone Number

_____
Physician's Address

_____ _____ _____
City State Zip Code

Mail to: Security Benefit Life Ins. Co.
Employer Benefits Administration
PO Box 750600 • Topeka, Kansas 66675-0600
1-800-888-2461 • Fax 1-866-477-6526

SECURITY BENEFIT®

Questions? Call our National Service Center at 1-800-888-2461.

Security Flex 125 Program® Medical/Dependent Care Reimbursement Program Claim Form

Instructions

Use this form to request medical expense or dependent care reimbursement. Complete the entire form. Please type or print

1. Complete the worksheet on the back of this form to itemize expenses and attach legible copies of receipts.
2. Must sign **Section 3**.
3. Completion of **Section 4** is optional, but will speed the processing of your claim.
4. This completed form and all required attachments should be mailed to:
   Security Benefit
   P.O. Box 750600
   Topeka, KS 66675-0600

1. Provide Personal Information

Employer Name _____

Name of Employee _____ _____ _____
First MI Last

Mailing Address _____ _____ _____ _____
Street Address City State ZIP Code

Social Security Number _____

Daytime Phone Number _____ Home Phone Number _____

2. Select Type of Claim

Please select one:

❍ **Dependent Care Reimbursement**
Requested Amount: $ _____

❍ **Medical Expense Reimbursement**
Requested Amount: $ _____

❑ Requesting **check** payment option.

❑ Please provide your bank information below if you wish to have payments from Security Benefit made by direct deposit to your bank account. If any information is missing your request may be delayed. You may also attach a void check to ensure necessary information is provided. Receipt by said bank of such credit entries shall be deemed receipt by you.

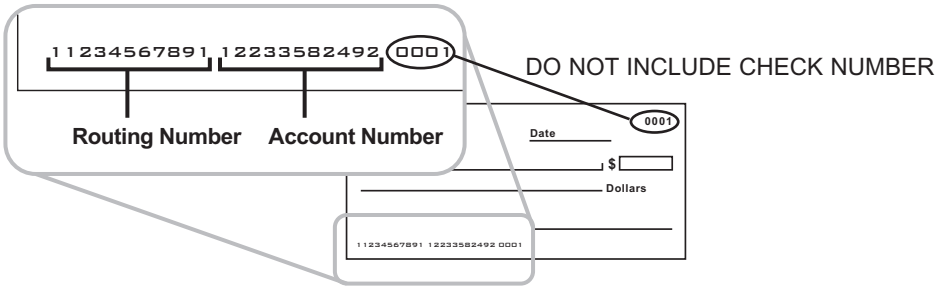
Bank Account Type (please check one): ❍ Checking ❍ Savings

Bank Name _____

Name on Bank Account _____

Bank Routing Number _____

Bank Account Number (Do not include the check number) _____



3. Provide Signatures

I agree:

- That this claim represents qualifying medical or dependent care expenses not covered/reimbursed by insurance.
- My signature below confirms my understanding and agreement with this requirement.
- I further understand that any claim that does not meet these requirements may result in this payment being considered a taxable payment by the IRS.
- I understand that the direct deposit arrangement will continue until Security Benefit receives written notification from me stating otherwise.
- This is to certify that I have incurred expenses that qualify for reimbursement under my employer's Security Benefit Medical/Dependent Care Reimbursement Program. None of these expenses have previously been submitted.
- I certify that these expenses will not be paid or reimbursed by any insurance company or from any other source or I may be subject to IRS fines and/or penalties of perjury. I hereby request reimbursement for these expenses to the extent allowable. I understand that at the end of the plan year all unpaid claims (even if less than $25.00) will be reimbursed in full and that any remaining fund balances at the end of the plan year will be forfeited to my employer.

X_____ _____

Signature of Employee | Date (mm/dd/yyyy)

4. Provide Summary of Itemized Bills

For each expense that you are submitting for reimbursement, you must provide all information below.

Name of Physician, Hospital Pharmacy or other Provider of Service	Description of service, if drug include name, days supply and quantity	Patient Name	Date of Service	Amount of Charge

Eligible expenses generally include health care expenses that are not covered, or only partly covered, by your health plans or, if you're married, by your spouse's health plans. Some of the expenses you can claim are:

Deductibles and co-payments under medical, dental, and prescription drug plans; Expenses for medical services or supplies not covered by your plans (for example, many plans do not cover routine physical or well-child care); Vision care expenses, including eye exams, eyeglasses, as prescribed by your doctor, and materials and equipment needed for using the eyeglasses such as eyeglass cleaner, contact lenses and contact lens supplies; Lasik, Laser eye surgery and Radial keratotomy; Hearing care expenses, including hearing exams and hearing aids; Expenses in excess of medical or dental plan limits (for example, orthodontic expenses greater than the limit set by your dental plan); Transportation expenses related to medical care; Nursing services not covered by your medical plan; Wheelchairs and crutches; Capital expenses for a personal residence to accommodate a disabled condition less the increase in your property value; Pregnancy test (over the counter); Certain over the counter drugs (with a prescription); Over the counter reading glasses when accompanied by a prescription; Smoking cessation program; Weight loss program when it is prescribed by your doctor for a specific diagnosis.

Expenses that are not Eligible

Most cosmetic surgery; Health club dues; Electrolysis; Over the counter vitamins, even when prescribed by a physician; Dietary supplements; Teeth whitening products; Insurance Premiums of any nature.

For expenses that are not listed you can refer to IRS Section 213 for more complete information or contact Security Benefit at 1-800-888-2461.

Mail to: Security Benefit • PO Box 750600 • Topeka, KS 66675-0600 or
Fax to: 1-866-477-6526
Visit us online at www.securityflex.com • E-mail: ebdept@securitybenefit.com

Our Pledge

Regarding Medical Information

We are committed to protecting your personal health information.

We are required by law to:

1. Make sure that any health information that identifies you is kept private;
2. Provide you with certain rights with respect to your health information;
3. Give you a notice of our legal duties and privacy practices;
4. Follow all privacy practices and procedures currently in effect.

Summary of Security Benefit Privacy Practices

Summary of Privacy Practices

This Summary of Privacy Practices summarizes how personal health information about you may be used and disclosed by the group health plan (the "Plan") offered or administered by Security Benefit (SB) in which you participate, or by others, in the administration of your claims. This Summary of Privacy Practices also summarizes certain rights that you have with respect to your personal health information. For a complete, detailed description of all privacy practices, as well as your legal rights, please refer to the accompanying Notice of Privacy Practices.

How We May Use and Disclose Health Information About You

We may use and disclose your personal health information without your permission to facilitate your medical treatment, for payment for any medical treatments, and for any other health care operation. We will disclose your health information to employees of SB for plan administration functions. We may also use and disclose your health information without your permission as allowed or required by law. Otherwise, we must obtain your written authorization for any other use and disclosure of your health information. We cannot retaliate against you if you refuse to sign an authorization or revoke an authorization you had previously given.

Your Rights Regarding Your Medical Information

You have the right to inspect and copy your health information, to request corrections of your health information and to obtain an accounting of certain disclosures of your health information. You also have the right to request that additional restrictions or limitations be placed on the use or disclosure of your health information, or that communications about your health information be made in different ways or at different locations. You may also restrict access to your Protected Health Information if you pay for your medical services in full, outside of the plan.

How to File Complaints

If you believe your privacy rights have been violated, you have the right to file a complaint with the Security Benefit Privacy Officer or with the U.S. Department of Health and Human Services – Office for Civil Rights. We will not retaliate against you for making a complaint.

Security Benefit Privacy Officer
James T. Janousek
Security Benefit
One Security Benefit Place
Topeka, Kansas 66636-0001
Telephone: 785-438-3038
Fax: 785-368-1353

Region VII – IA, KS, MO, NE
Office for Civil Rights
U.S. Department of Health & Human Services
East 12th Street – Room 248
Kansas City, MO 64106
Telephone: (816) 426-7278; (816) 426-7065 (TDD)
Fax: (816) 426-3686

SECURITY BENEFIT
NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2004
Last Updated: November 1, 2010

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you about the ways in which Security Benefit (referred to as "the Company") may collect, use, and disclose your protected health information, and your rights concerning your protected health information. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of the health care to you, or the payment for that care. Protected Health Information also includes your genetic information as defined in Section 201 of the Genetic Information Nondiscrimination Act of 2008.

The Company is required by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Company may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment.

- Payment. We use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment.
- Health Care Operations. We use and disclose your protected health information in order to perform our planned activities, such as quality assessment activities or administrative activities, including data management or customer service. In some cases, we may use or disclose the information for determining health care insurance premiums.
- Treatment. We may use and disclose your protected health information to assist your health care providers (doctors, mental health practitioners, pharmacies, hospitals, ambulance services and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.
- Plan Sponsor. If you are enrolled through a group health plan, we may provide enrollment/disenrollment information and summaries of claims and expenses for enrollees in a group health plan to the plan sponsor, who may also be an employer.
- Enrolled Dependents and Family Members. We will mail explanation of benefits forms and other mailings containing protected health information to the address we have on record for the subscriber of the health plan.

OTHER PERMITTED OR REQUIRED DISCLOSURES

- As Required by Law. We must disclose protected health information about you when required to do so by law.
- Public Health Activities. We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
- Victims of Abuse, Neglect or Domestic Violence. We may disclose protected health information to government agencies about abuse, neglect or domestic violence.
- Health Oversight Activities. We may disclose protected health information to government oversight agencies (e.g., state insurance departments) for activities authorized by law.
- Judicial and Administrative Proceedings. We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.
- Law Enforcement. We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- Coroners, Funeral Directors, Organ Donation. We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.
- Research. Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.
- To Avert a Serious Threat to Health or Safety. We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- Special Government Functions. We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- Workers' Compensation. We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.
- Health Information That is Not Protected. We may disclose health information about you that is not "protected health information;" that is, information used in a way that does not personally identify you or reveal who you are.

OTHER USES OR DISCLOSURES WITH AN AUTHORIZATION

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under a health plan.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION
You have certain rights regarding protected health information that we maintain about you.

- Right to Access Your Protected Health Information. You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment, or case/medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.
- Right to Amend Your Protected Health Information. If you feel that protected health information maintained by us is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by us, or if you ask to amend a record that is already accurate and complete.
- Your Rights if a Request is Denied. If we deny your request to amend your protected health information, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to disagree with that statement.
- Right to an Accounting of Disclosures Made by Us. You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, to payment, to health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes. Your request for an accounting of disclosures must be made in writing and must state a time for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2004. Your request should indicate in what form you want to receive the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting but we will tell you the cost in advance.
- Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information. You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. We may not agree to your request. If we do agree, we will comply with your request unless the information is needed for an emergency. You may also restrict access to your Protected Health Information if you pay for medical services in full, outside of the plan.
  Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.
- Right to Receive Confidential Communications. You have the right to request that we use a certain method to communicate with you, such as paper or electronic communication, or that we send information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- Right to Notice of Breach. You have the right to be notified of any breach of your Protected Health Information, except the unintentional, access, or use of information that does not meet the definition of "breach" pursuant to applicable guidance from the Department of Health and Human Services.
- Right to a Paper Copy of this Notice. You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.
- Contact Information for Exercising your Rights. You may exercise any of the rights described above by contacting our Privacy Office. See the end of this Notice for the contact information.

HEALTH INFORMATION SECURITY
Security Benefit requires its employees to follow the SB security policies and procedures that limit access to health information to those employees who need it to perform their responsibilities. In addition, SB maintains physical, administrative and technical security measures to safeguard your protected health information.

CHANGES TO THIS NOTICE
We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. We also post a copy of our current Notice on our intranet website. Any time we make a material change to this Notice, we will promptly revise and post the new Notice with the new effective date.

COMPLAINTS
If you believe that your privacy rights have been violated, you may file a complaint with us and/or the Secretary of the Department of Health and Human Services. All complaints to Security Benefit must be made in writing and sent to the privacy official listed at the end of this Notice. We support your right to protect the privacy of your protected health information. We will not retaliate against you or penalize you for filing a complaint.

CONTACT SECURITY BENEFIT
If you have any complaints or questions about this Notice or you want to submit a written request to Security Benefit as required in any of the previous sections of this Notice, please contact:

Security Benefit
James T. Janousek
Privacy/Compliance Officer
One Security Benefit Place
Topeka, Kansas 66636-0001
Phone: (785) 438-3038
Fax: (785) 368-1353

You may also Contact:
HHS Region 7 – Kansas City, MO
Office of Civil Rights
1201 Walnut, Suite 2334
Kansas City, MO 64106
Phone: 816-426-3697

Service Options

Web Access
The 24-hour website for your Section 125
Flexible Spending Account is **www.securityflex.com**
Click on the Security Flex 125 Program® icon.

Fax Access
For 24-hour toll-free fax access for flex reimbursement,
call: **1-866-477-6526.**

Phone Access
For personalized telephone support,
call **1-800-888-2461** toll free,
Monday-Friday from 8:00 am to 5:00 pm Central Time.

SECURITY BENEFIT®

One Security Benefit Place • Topeka, Kansas 66636-0001 • securitybenefit.com

38-08474-00 2010/11/30